United Lincolnshire Hospitals NHS Trust

Report to:	Trust Board
Title of report:	Quality Governance Committee report to Board
Date of meeting:	30th May 2017
Chairperson:	Penny Owston Non Executive Director
Author:	Bernadine Gallen Quality and Safety Manager

Purpose	This report summarises the assurance received and key decisions made by the Quality Governance Committee (QGC). The report details the strategic risks considered by the committee on behalf of the board and any matters for escalation for the Board to respond. This assurance committee meets monthly and takes scheduled reports from Trust operational committees according to an established work programme.
Assurance received by the committee	**Safeguarding** Chemical restraint All wards have been issued a log book so any time they administer a chemical restraint for agitated or distressed patients they have to document this on the log which will be audited. Statement support There is a national statement for modern slavery which has been added to the website Funding The team have had agreement to fund administrative support Bradbury Plan The pan has been agreed and will be presented at QGC Audit Section 2 audit of the children's act will be commencing soon – LCHS will audit ULHT and ULHT will audit LCHS.
	Patient Experience The patient experience report reflects what we know as an organisation especially in relation to A&E and we are assured data is shared with the Clinical Directors to help affect change. Friends & Family Test (FFT) There is a national temperature check for the Trust against all other NHS acute trusts. The FFT does not provide results that can be used to directly compare providers because of the flexibility of the data collection methods and the variation in local populations. This means it is not possible to compare like with like. There are other robust mechanisms for that, such as national patient surveys and outcome measures. The Trust is well above the national average for response rates across emergency care and outpatients and only

	slightly below for inpatients. Complaints The Trust has achieved 80% with responding to complainants within the timescale allocated. The top theme is clinical treatment. ULHT have been approached by Care Opinion to become one of a few trusts to pilot and test an innovative way to seek online patient feedback using pictures. The Trust has a number of initiatives relating to how we ensure carers are recognnised, involved and informed about a patients care. Dementia bundle currently being developed Discussion around using cards instead of the text message however there is a cost implication of we use cards to improve response compliance. Action: Chief Nurse to discuss with Deputy Chief Nurse using cards instead of text messaging
	Quality Account (QA) To note The first draft of the Quality Account was presented and within the key priorities for 2017/18 to add in pressure ulcers. The draft report has been submitted to KPMG, CCG and Healthwatch. It has also been circulated widely within the trust for comment. The QA has to be uploaded to NHS Choices by the 30th June 2017. Action: To present the final QA at the June meeting
	Patient Safety Committee & Clinical Effectiveness ToR To note The ToR have been updated but will be re-reviewed as there is a new Medical Director Action: to be more specific around internal audit
	BAF The committee are assured processes are in place and no changes required.
Assurance have not been received by the committee	**Fire** – Lead was not present to update the committee. There needs to be agreement to which committee this item is discussed as currently it is on the FSID and QGC work plans. Action: QGC chair to discuss with chair of FSID
	Diabetic Ketoacidosis (DKA) Lack of assurance as action plan was not submitted to the committee. It has highlighted the DKA policy was not adhered to and has raised concerns on how we care for patients admitted with DKA and how the diabetic team link to the community. The NHSi has commissioned a review of the Diabetes service reviewing the policies, processes and staffing. The Trust is currently agreeing the ToR with the lead of the review with a planned start date in July 2017 with the report being available in September 2017. Immediate actions were implemented for DKA patients:

	• all patients to be reviewed by a medical registrar • all patients to be under the care of the Diabetologist • relaunched policy • any issues relating to DKA is an automatic SI Action: Dr Hepburn to request the action plan from the DKA audit and NHSi report to be an agenda item on the October 2017 meeting
	Infection Control TB An extraordinary meeting with external partners including PHE to discuss the patients with TB has occurred. They did not identify any lapses in care however there was one issue identified at Lincoln – the swabs were not reviewed until post discharge. The nurse was caring for the patient for less than 8 hours and had applied appropriate PPE. There is an issue with our positive/negative pressure rooms as there is no negative pressure rooms that meet the required standards of a negative pressure room. Patients with standard TB will be cared at ULHT and any patients with multi-resistant will be transferred to Nottingham or Leicester Bare Below the Elbows (BBE) Staff are non-compliant as they are going into clinical areas and adhering to the BBE policy. Chief Nurse relaunching BBE policy and dress code policy is being revisited Norovirus There was a major norovirus outbreak at the Lincoln site and the policy was followed in relation to the outbreak management. It has highlighted there has been significant capacity within the Infection team. The bays also do not have doors which does not allow for patients to be nursed as a cohort. Funding has been agreed to appoint a band 5 and band 4. Funding has also been agreed to put doors on the bays in MEAU. Decontamination The Trust does not have a decontamination lead which has been raised with Pathlincs. The Trust has highlighted their concern with the lack of Microbiology support and are going out to other organisations for support. Newly appointed HoN at Pilgrim is a DIPSI in his current role so will be the decontamination lead for ULHT. Deep Clean The Trust does not have an annual deep clean programme due to the high bed occupancy rate and no decamp wards. It also has a small team and currently it can take 72 hours to deep clean a ward. The Trusts cleaning scores are also below acceptable target. Action: Chief Nurse to add to risk register
	Information Governance (IG) Training The compliance for IG was 90% hence we did not achieve the 95% target. Action: IG lead to attend the June QGC to update on how to

	improve compliance. WhatsApp - To note The committee would be assured of its use if it was part of a disaster management plan or for a key group of staff with a very clear remit not to exchange patient data. Action: If it is agreed the social media policy would need to be updated to include WhatsApp.
	Upward Report from Patient Safety & Clinical Effectiveness Committee Mortality HSMR (February 2016 to January 2017) is 103.84 and is within expected limits. SHMI (October 2015 to September 2016) is 110.30 and is within expected limits. Lincoln is alerting for both HSMR and SHMI. There is a new alert for COPD and Bronchiectasis driven by Boston as per agreed procedure a deep dive will be initiated. Comorbidity Audit An audit of 21 patients was conducted reviewing the Comorbidites on patients over 75 years of age with a 0 Charlson Score. The main findings are: • 90% (19/21) did not have all comorbidities coded. • The majority of these comorbidities are from the patients history not being recorded within the patients final episode. • 67% (14/21) did not have Charlson index comorbidities coded. • The charlson index comorbidities score adjustment for the 14 patients equates to 263 which will have an effect on our expected mortality used to calculate our HSMR and SHMI. • All comorbidities not coded affect the risk adjustment within Dr Foster therefore our expected mortality will be lowered due to these omissions. • All comorbidities that haven't been coded would affect the income and the Best Practice Tariff (BPT). Quality Governance Team and the Deputy Medical Director are meeting to develop a plan. Lincoln Mortality Review An in-depth review was conducted due to the high HSMR and SHMI on the Lincoln site. The main findings are: • Lincoln County Hospital have less patients coded within the Charlson Comorbidity index and lower age patient base than the comparative site PHB, however LCH is in line Nationally. • LCH's average length of stay is higher than average for patients that stay 0-20 days. • LCH have a lower than average proportion of expected palliative care coding. • An amalgamation of lower than expected rates on the above will affect the expected rate percentage within Dr Foster thus driving the HSMR higher than average Quality Governance Team and the Deputy Medical Director are

	meeting to develop a plan. WHO There were 3 episodes of non-compliance with a Trust compliance of 98.9% Action: Letters are sent from the CD to all consultants who have not adhered to the WHO policy Deteriorating Patients Of the 239 arrests in 2016 6% of patient records did not demonstrate that agreed NEWS protocol had been followed. The Chief Nurse stated she had attended Morecambe Bay hospital and they found nurses were not completing the 2 am observations as they did not want to disturb patients and when they topped this practice the cardiac arrests decreased by 60%. Action: Further information from IR1's were requested by the committee to draw out themes and learning and frequency of reporting to patient safety committee increased to quarterly. Q& S manager to contact the Resus Lead re observations at night.
	Quality Report Falls There is an increase in number of falls with harm at Boston. Falls and falls with harm have decreased at Lincoln and Grantham. Ongoing work includes review of the Falls Policy, implementation of ward accreditation and development of learning from the NHSi Collaborative work. Deeper dive into concern wards is required and will be picked up by the Lead Nurse for Patient Safety to ensure that high falls numbers and repeat fallers are appropriately scrutinised. Pressure Ulcers In April there were the following grades of Hospital Acquired Pressure Damage:- 29 Grade 2, 4 Grade 3, 4 Grade 4 A full thematic review of Pressure Damage at Boston has been undertaken. Issues resulting from this thematic review are incorporated into the Trust Pressure Ulcer Improvement Plan which will be monitored through the ULHT Pressure Ulcer Prevention/Reduction Committee. Review of pathway for patient non-concordance to ensure that risks are clearly outlined to patients and documented in full within patient notes. All pressure ulcers have planned scrutiny panels in the diary. Medication Of the 144 incidents reported the majority (84.7%) were classed as resulting in no harm. • 26% of the no harm incidents were due to omitted medicines. • 73 (51%) of all the events recorded were associated with priority/high risk drugs. • 40 (28%) of all incidents reported were due to medicines being omitted. • 20 (13.9%) incidents reported were due to prescriptions having

	wrong/unclear drug doses or strengths. Action: Q&S manager to review if any incidents were related to insulin Sepsis Compliance with screening has achieved 99% and administration of IVAB has achieved 85.88%. The rollout of the sepsis eBundle is ongoing and a 2017/18 milestone plan has been developed. Action: Non executive team to visit wards who have are live with sepsis eBundle
	Adverse Incidents The Trust has 143 SI's categorised as "Open" on ULHT's SI Tracker. The highest number of open SI Investigations are with Lincoln County Hospital A&E Department and Ward 7B at Pilgrim Hospital, both with 9 investigations underway. 74 investigations are beyond the deadlines. There are 74 SLE's currently open, with all of them being overdue. A breakdown of the SLEs reported, with the greater number being recorded for A&E, followed by the Labour Ward / Delivery Suite and Operating Theatre. It is noted that there will be no further recording of SLEs as all serious incidents will be recoded as SIs and recorded on STEIS. There were 1280 incidents recorded in April 2017 with the majority being No Harm at 859, Low Harm at 186 and Moderate Harm at 78. There were 943 patient related, 155 staff related and 48 business related. Of the incidents reported with a severity of Moderate or above during April 2, 12 incidents had been identified on DATIX as requiring Duty of Candour, but only 5 of these incidents were recorded on Datix as having had a Duty of Candour apology given although evidence in the form of a letter attached to Datix is only available for 2 incidents. Upgrade to Datix was planned prior to cyber-attack. A business case and specification has been developed for an updated system. Lessons learnt being incorporated from Morecambe Bay. Interim for 8 weeks reviewing the SI process.
	Duty of Candour (DoC) The results demonstrate poor compliance with DoC. An improvement plan has been developed with key milestones. A dedicated report will be generated. Policy will be refreshed, training programme being developed and improve the recording on Datix.
	Risk Report The committee are assured processes are underway but not assured where risks sit and which method to mitigate. There is a risk improvement plan in process. This is the first month that all corporate risks have been reviewed and updated. There are currently 123 corporate risks. All new risks are being validated. Action: Risks with the same themes will be grouped eg staffing issues under one risk for the Trust. The risks also need to be aligned with our regulatory requirements and cross referenced with the capital programme board. The joint QG and FSID risks to be

	reviewed by the chair of QGC and FSID.
Areas identified to visit in walk rounds	The non-executives to visit wards that are live with sepsis eBundle.

Attendance Summary for the rolling 12 month period

Voting Members	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**
Penny Owson,Non-executive Director(Chair)	√												
Paul Grassby, Non-executive Director	√												
Kate Truscott, Non-executive Director													
Neill Hepburn, Interim Medical Director	√												
Michelle Rhodes, Director of Nursing	√												
Non-voting members													
Jennie Negus, Deputy Chief Nurse	√												
Bernadine Gallen, Quality & Safety Manager	√												
Karen Sleigh, Head of 2021 (agenda item)	√												
Sarah Southall, Deputy Chief Nurse LECCG	√												